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An Observer Looks at Group Hospitalization

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ONE of the most amazing developments in the hospital field of the past few years has been that of the plans whereby for a stipulated monthly or annual sum individuals, or groups of individuals, are assured of hospital care without further charge in case of illness. Undoubtedly these plans have been greatly assisted by the economic depression, which turned the attention of both the public and the hospitals to the necessity of some such form of finance for hospital care, but the major factor in this remarkable wave of public enthusiasm has been the focussing of attention by all classes of society upon social and economic changes and reforms, upon "social security" and upon possible solutions by means of insurance of different types. This is an "insurance age."

What is new? One really needs a ticker tape to keep up with things. One thinks of the speedster who shouted to his companion, "This is a nice town we're coming to, wasn't it?" The New York City Plan, hardly out of didees, has, or had a few weeks ago, some 475,000 members! The St. Paul plan is well over 100,000, and Rochester and Cleveland are not far behind. Popular interest has been aroused and public confidence created. While some of the older plans are fairly stationary in membership, the newer ones are maintaining a satisfactory curve of growth, statewide plans have been launched, and for two years back there has been talk of a continent-wide plan. Of course a number have national and even foreign coverage.

Plans in Canada

As far as I know, none of the 28 or 30 plans in Canada (with the possible exception of one) have been discontinued, and they are, on the whole, enjoying a steady though not spectacular growth. None of the plans have shown anything like the growth of the large plans in the United States, possibly because, with the exception of plans in Edmonton and Kingston, no city-wide plans have been in operation. The Edmonton plan now has over 5,500 members; Kingston has about 1,500. The town of Kamloops, B.C. has a plan which now covers some six thousand people. The plan at Listowel, reported to this meeting last year by Mr. Schinbein, is proving quite successful.

A new plan has been started this year in Moncton,N.B., on a city-wide basis, and one will be launched shortly at Revelstoke, B.C. A rural plan, centred about a number of rural hospitals in the area north of Edmonton, has been started recently.

No definite action has been taken as yet in Montreal, Toronto, Winnipeg, Hamilton, Saint John, and other cities considering city-wide plans. The plan in Toronto, which was nearing completion, has been held in abeyance pending the development of the Associated Medical Services, Inc., a medico-lay non-profit organization endorsed by the medical profession and covering medical as well as hospital (in part) charges. The cost is $2.00 per month per individual, or $6.50 per month for a family of four. For this there will be coverage for general practitioner and specialist care and a sum of $3.50 per diem paid towards the hospital expenses. Units have been started in Toronto, Simcoe and Woodstock. While the cost is higher, the coverage is much more extensive. In Montreal the Medico-Chirurgical Society has been investigating group hospitalization for some months.

In Lethbridge one contract under a plan of insuring families at $12 per year was found very unsatisfactory and, in the past four years has cost one hospital over $5,600. A new Community Club contract with a $10 fee and a charge of $1.00 per diem while hospitalized is now being urged. The hospitals, after an experience with con-

flicting plans, recommend a joint plan with free choice of hospital. New Glasgow, N.S., has a type known as a Householders' Contract, whereby for one dollar a month for family coverage, or for seventy-five cents a month for single subscribers, the sum of two dollars is allowed for every day of hospitalization.

Present Status of Plans

It would appear that these plans, which Haven Emerson has aptly described as the "facilitation of collective thrift", are now firmly established. Some misgivings might be voiced concerning the renewals after the first wave of enthusiasm has passed off, but a number of the plans have been in operation sufficiently long (one Glace Bay plan dates back thirty-five years) to indicate that, if the plans continue beneficial, support will be maintained. It is interesting to note that *no non-profit, free-choice plan has ever been discontinued, or failed to meet its obligations to subscribers or hospitals.**

Many of the plans are accumulating tidy surpluses and are now planning to either increase the benefits or reduce the premiums. With more accurate data available, the inclusion of dependents is being more widely developed and the added risk of enrolling individuals, as opposed to groups, is being better appraised.

Attitude of National Organizations

It is of considerable interest to note the official pronouncements of hospital and medical organizations respecting group hospitalization. The American Hospital Association in 1933 endorsed the principle and formulated a series of essential stipulations. In 1934 the American College of Surgeons approved the general principle also. The Catholic Hospital Association has been very cautious in its resolutions for some time, but this year agreed (No. 35) that is "now desires to encourage its members to subscribe to such plans which really subserve a welfare program, have been originated or at least approved by the local medical society, are sound actuarially and financially, leave to the patient the free choice of hospital and physician, and otherwise conform to acceptable standards in such organizations."

The Canadian Medical Association, which has had a special committee studying group hospitalization for some time, has approved group hospitalization as "fundamentally sound." The American Medical Association has not officially endorsed nor disapproved of group hospitalization, although its general attitude in previous years was in opposition. However, at the 1937 meeting a group of principles to safeguard all parties concerned was adopted. These are similar in principle to those of the American Hospital Association and would seem quite reasonable, although there would probably be considerable difference of opinion over one differing clause (No. 4) which states that, "The subscriber's contract should exclude all medical services." This requirement would exclude radiology and pathology, unless a technical service only be rendered—and this is highly undesirable as the Cleveland experiment showed.

One of the most desirable developments of recent years has been the creation of the Committee on Hospital Service of the American Hospital Association, under the Chairmanship of Dr. Basil C. McLean and with Mr. C. Rufus Rorem, Ph.D., C.P.A. as full-time Director. Subsidized by the Rosenwald Fund this Committee is making a careful analysis of the present trends, and is doing much to mould the newer plans. It is of particular value as a tie-in between the hospitals as a whole and these various plans, a tie-in the value of which may become more apparent in years to come, for there is a very potential danger of these movements running away with themselves and, unlikely as it would seem now, taking a dictatorial attitude to both the hospitals and the professions. For that reason I feel it very essential that the hospitals and the medical profession link in with those movements.

Statistical Summaries

Recent data compiled by this Committee is of value to those developing plans. The average hospitalization of subscribers is somewhat less than one hospital day per subscriber year. Employed people are hospitalized less than dependents under similar conditions. Payroll deduction subscribers are the best risks. About ten per cent of the average membership is hospitalized annually. The average length of stay in the aggregate is approximately nine days—shorter than for other hospitalized cases. One-third of the admissions are for a period of three days or less.*

Likely Developments

The future is not entirely clear. Undoubtedly there will be success for the immediate future. One would anticipate a greater inclusion of dependents and a gradual extension of benefits, as reserves prove adequate. One would anticipate also a general demand for inclusion of medical and nursing care. These demands are now being heard, not only from the subscribers but from the professions themselves. One can foresee a possible amalgamation or merger of many local plans into one large organization.

So far, so good; but other factors will enter. With greater benefits will come greater costs. It will become increasingly difficult for Mr. Average Man to bear the full cost of complete coverage for himself and family. Moreover, the plans do not really help many who need most help. The unemployed and the poorly paid are not considered in most plans. They need help as much as anyone. Also much is said at meetings about the "better risks"; this is but natural and is almost essential in a co-operative voluntary plan, but what about the poor risk, the man or family going from one illness to another? Something must be worked out for them, for the present plans are all trying to avoid them.

Group hospitalization is admittedly only intended to alleviate one major expense in sickness to one major group of the population. The more comprehensive medical and hospital type of coverage is more desirable provided the cost be not beyond the reach of the average bread-winner. I see a distinct possibility of the government being asked to subsidize these plans in various ways. We never seem to have any objection to having a portion of the cost converted from a visible to an invisible contribution. However, when this occurs the way is paved for varying degrees of state control. It is not inconceivable that the present plans may ultimately lead to and may be

*Rorem, C. R., Hospital Care Insurance, American Hospital Association, September, 1937.

*Report of the Committee on Hospital Service, 1937. American Hospital Association.

supplanted by some form of generalized state sponsored or directed plan.

In conclusion one would express the opinion that the better organized plans have proven their worth; moreover one would voice the hope that the voluntary nature of these plans may be preserved. The state could subsidize and could set up any necessary safeguarding regulations, but the direction could be best left to voluntary bodies. On the other hand, if the day should come when voluntary control would be abused or permitted to strangle the hospitals and professional groups, we might even agree that rigid state regulations might prove highly advantageous.

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The Scope and Functions of the Advisor to Schools for Nurses

By

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THE office of Advisor to Schools for Nurses is still new enough to justify the query — what is the scope and function of the individual who fills it? As we shall see, it is a question that is not readily answered.

The work of the Advisor brings her into contact, directly and indirectly, with the community, educational and legislative bodies, members of the medical and nursing professions, hospital boards, and hospital administrators. The scope and function of her work and its results are largely determined by the support and co-operation that she succeeds in obtaining from these groups. Not being too directly identified with any of the recognized fields in nursing or hospital work, the advisor may take a more objective attitude than those who are and serve to unite and to strengthen the various efforts by which the same end is reached. There is not an organization that has not something too good to be lost. So the advisor may become the medium for exchange and even a messenger of good news.

"Curriculum" and "Nursing Education" are words that I believe have become anathemas to hospital administrators. It is only through interpretation that we come to see them as the methods by which we are going to procure better service for the public and more satisfied individuals rendering it; that we recognize in students our future public health and private duty nurses; hence Schools for Nurses as the direct concern and interest of lay as well as professional groups. Is it too much to hope that the School Advisor may serve as a connecting link?

In a paper entitled "Who Is Concerned with Reform in Nursing Education", a lay authority answers his own question by saying, "Teachers in schools of nursing, those members of the profession occupying executive positions, state and provincial education officers, of course, but the public is also concerned with the quality and quantity of professional service; hence it is concerned with professional education. It is just as much concerned with nursing education as with medical education, or with the training of teachers. The community's responsibility in this matter is plain, they must be educated to understand this, Experience has shown that it will pay as soon as it understands."

Growing interest on the part of lay organizations is one of the most encouraging of recent developments for nurses. Therefore, one of the primary functions of the advisor must be to supply and to interpret pertinent information and to stimulate interest in nursing in all its implications. She should serve as one of the most fruitful channels through which community needs and nursing problems become known to the public.

While Advisors—school visitors—call them what you will, are still few in number, not even covering the nine provinces in Canada, and the movement is yet looked upon as an experiment by many, we have travelled a long way in education since "Supervision" was regarded as "Inspection" only, and visits were in the nature of investigations. In discussing the functions of the Advisor, Dr. Weir in his "Survey of Nursing Education In Canada", visualizes her as working with the advice of a representative committee. He speaks of her position as one that should be advisory and educative rather than inquisitorial, but vested with authority and supported by the best representation that the community has to offer.

Qualifications of the Advisor

What of her preparation? In the Weir Survey we meet her as an inspector, and we find that she should have academic standing equivalent at least to matriculation; many to-day feel that university qualifications should be a requirement. She should preferably have had experience in teaching in a public school, as well as in a school for nurses. Dr. Weir adds that a normal school training should prove a distinct asset. He also recommends that she should have at least five years of nursing experience, including private duty, successful experience as a Superintendent of Nurses in a hospital of at least medium size, and post-graduate work in a Canadian or other approved university. I should like to extend this preparation to ensure a practical understanding of public health problems.

We all agree that the Advisor must be possessed of tact,

sound judgment, and of a personality that instills respect and merits co-operation, and that she must have a sound grasp of the principles of education; but with all this she must be intensely human, with a sympathetic understanding of individual difficulties and weaknesses. She must be a woman of maturity, with broad experience of a cultural as well as of a professional nature.

Her Work and Concern

The Advisor and her committee concern themselves wtih all that affects minimum standards, curriculum, supervision, and registration of all schools meeting the minimum requirements, and last, but of great importance, are the Advisor's visits and her reports as a result of these. Her concern is primarily with the teaching of students, but we know that good teaching can only take place where good nursing is effected, so she must become familiar with nursing practices as carried out in each institution. In the latter recommendation is implied a responsibility to potential students, who out of an abundance of information, often meaningless to them, have to choose the school with which their future is to be permanently identified. None of us will question the right of a student to know what recognition she will later receive as a graduate of the school of her choice.

It has been remarked that curriculum, soundness of teaching methods, qualification and preparation of the staff and all that affects the tone of the school are more important than the style of architecture or equipment. A statement that we are very willing to accept, while remembering that certain factors regarding building and equipment have a direct bearing on present teaching, and on the future progress of any school. More and more, in general education are certain physical facilities recognized as essentials to good teaching.

To use modern equipment intelligently does not mean to use it mechanically. Human and physical equipment have been rightly termed, "The chart and compass that the student uses on her voyage of exploration and discovery." It is not suggested that the explorer who starts out with his equipment in as good condition as possible, and with an intelligent understanding of its use, is handicapped in meeting an emergency later. Modern equipment, good teaching facilities do not detract from a student's resourcefulness—the methods by which she is taught to use them may. The best equipment in the world, the most modern appointments, are of little use in the hands of overworked, inadequately prepared or indifferent students or poor teachers. Unless good records are kept it is impossible to interpret the value of the experience that the student has had. So all these things must become the concern of the Advisor, yet the selection of the student nurse and her preparation to meet present and future needs, remain a direct responsibility of each hospital that undertakes to conduct a school. How often are nurses called upon to answer criticisms, and explain professional deficiencies, due to faulty preparation or to the failure of individuals in whose direction and training they have had no part.

Undertaken in a spirit of co-operation and understanding, there are many reasons why personal visits are important. In order to carry on effectively, the Advisor must adapt her ideas to local needs and how can we really understand these if we do not come into actual contact with them? By the use of questionnaires, someone may say. But how many of us have filled in questionnaires, as truthfully as possible, and sent them on their way, realizing that they are but poor word pictures of the actual situation? A few minutes spent in conversation, or a few hours of actual contact are much more enlightening. Special preparation for the teacher is generally accepted as an essential, but the attendance at two or three classes reveals more about the *quality* of teaching than many letters after an instructor's name. Suggestions, the result of consideration after being in touch with busy wards, harassed hospital executives and depleted bank accounts, are apt to be more fruitful than those formulated at an office desk. Through a visit of discernment, not one of criticism alone, a closer relationship is established. Any hospital that assumes the education responsibility of conducting a school for nurses should be privileged to receive adequate supervision by one competent to carry this out. Registration of professional institutions has been described as the first step in safe-guarding the licensing system of the province and in protecting the public.

As a former Superintendent of Nurses, I can readily see other advantages that we hope to gain from visits. Burdened by routine or overwhelmed by its many interruptions, lacking outside incentive, we are too apt to welcome less strenuous days as periods for relaxation, rather than as times for accomplishment. It is a natural reaction, but not a health attitude for the progress of the school. All business concerns recognize the necessity for at least a yearly audit. It is essential before we can pronounce with any degree of assurance, that our accounts are in order.

What if preparations are made for these visits? Such preparation must entail self-analysis, evaluation and even re-organization. Temporary changes perhaps, but a recognition of the need for them. Our most effective efforts are frequently put forth for the guest whom we can respect, and with whom we feel free to discuss and to share our problems. The visitor I picture would be sincerely welcomed by the Superintendent of Nurses, and leave her feeling cheered and encouraged, above all with an incentive for further endeavour, not deflated and resentful. Nor does this suggest the quiet acceptance of undesirable conditions, nor the condoning of weaknesses that should not exist. The most lasting reforms are the result of co-operative effort, and continuous, rather than sudden change; reforms made in response to a need that is felt.

A Combination of Duties

It seems well that in many provinces the duties of Registrar have been combined with those of School Advisor. As Registrar, the Advisor becomes familiar with Association problems. As Advisor, she deals directly with the nurse as a student and later with her as a product of the education that she should share in planning and directing. The time no doubt comes, when a separation of duties is desirable, even essential, but the Advisor's interest and contact with Association affairs should continue. She must never lose touch with the actual conditions in the community or with nursing requirements. Her usefulness depends upon a practical appreciation of these.

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Business Methods in Dealing With Patients

By

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THE relationship of patient to hospital may not be compared to a customer and a commercial enterprise, and rules laid down for the guidance of a collection department in a commercial concern are not always applicable to hospitals. The jobber may accept or reject purchasers. As a rule a transaction in a store involves value received in the form of a tangible article, whereas the hospital dispenses a commodity known as service, which after being proffered and used, cannot be reclaimed and put back into stock. Only in the maternity department may service be planned for and expected yet difficulties are sometimes encountered there. It must be remembered that neither the hospital nor the patient can exactly calculate his expenses in advance. Even with flat rates it is sometimes impossible to predict what circumstances or unexpected complications might delay recovery. When the purchaser buys a rug or a car, he may remain at his employment and pay from income. When the patient buys hospital service, his income may be seriously hampered, if not cut off, while his expenses are increased. He must often think not only of himself but of family obligations if he has dependents. It must be established, then, that there are many things to be met with in the relationship of hospital to patient-debtor that are unknown in commerce.

A patient is a part of the shadow of the general public. What happens to him is soon spread throughout the community. The reaction of one outraged patient-debtor will destroy in a brief period much of the goodwill laboriously built up by a hospital administrator. We must always remember that ever present shadow of John Q. Public. Whether his gestures toward the hospital include the clenched fist of resentful menace or grateful outstretched hands of thanks and appreciation rests with us. It is vitally important then that every hospital should strive to collect the utmost obtainable on accounts receivable, but it must be consistent in its methods and under no circumstances utilize in a general way a policy of harshness that sacrifices the respect and goodwill of the intelligent members of the community.

Hospitals must face the fact that within the last few years sufficient publicity has been given to the subject of social medicine to account in great measure for the attitude of many persons that the hospital is established in a community for their personal use without regard to their ability or willingness to pay. Surprisingly enough this view is not restricted to our illiterate or semi-literate population. It is widely shared by radical thinkers who apply the theory to save their purses, and too often it is employed by politicians and influential people to secure benefits for certain individuals not fitting into any special category that would entitle them to hospital treatment in a given community. How many administrators have been berated and harangued by over zealous citizens, usually of the type best described as vicarious philanthropists, because hospital treatment has been refused to some non-emergency or non-resident applicant too lazy to employ means at his disposal to obtain care if truly entitled to it. It is a concrete fact that public discussion of socialization as it affects hospitals and doctors has developed a definite antipathetic reaction toward the sense of responsibility of many persons to meet their just obligations for hospital services rendered them. They feel that they have only partaken of a privilege which is their inalienable right, without regard to costs involved. This is seriously reflected by many who unscrupulously seek bankruptcy and farm compositions in an attempt to relieve themselves of debt.

Uniform Hospital Charges

There should be no competition between hospitals in the same community or even hospitals serving the same geographic areas. In some communities the formation of hospital councils adjust charges. To deliberately tinker with rates in order to obtain preferential benefits is not only unethical but subversive of everything a hospital stands for as a service unit in the community. There is a definite reason why the adoption of uniform rates is sometimes complicated; one which may be cited is that it is obvious that a denominational hospital with no salary overhead is able to reduce rates to a level which the hospital carrying a large salary schedule would find impossible to sustain. Apart from this basic inequality of costs it is advisable and preferable for hospitals in one community or area to adopt uniform charges. This is predicated on the supposition that all hospitals maintain precisely the same high quality of service, and provide the best of equipment, facilities and care available.

Charges within the hospital should be standardized. There is no logical reason why standardized flat rates could not be predetermined and do away with the ghastly parade of extra charges that tend only to confound the average patient. One may trace most of the dissatisfaction voiced by irritated patients to the weekly exhibit of special service charges which might just as easily be lumped together into a compact flat sum. When the obsolescent system of charging for bed and board plus 1001 extras is abolished much of our collection problem will have been solved.

Inasmuch as the failure or success in our business transactions is largely traceable to the admitting office, I would like to discuss the most practical admitting procedure with regard to financial arrangements. Is it advisable to have a separate credit department? Unless every reasonable effort is made to ascertain the exact economic status of the incoming patient and the utmost discretion used in arriving at a determination of his ability to meet his obligations, the set-up for ultimate collections is of no value unless he possesses actual assets to satisfy the claim.

The Admitting Procedure

The admitting officer is a most important link in establishing a good relationship between the incoming patient and the hospital. The responsibility should not be carelessly delegated to other officers without substantial reason unless, of course, it is someone in definite administrative authority. The admitting officer must by personal appearance and diplomatic manner instill confidence in the patient, his relatives and friends. There must be a thorough understanding of the psychology involved. Without patronage, the admitting officer must possess a maximum amount of tolerance, good nature, intellectual keenness modified by a warm and generous understanding, and an unlimited quota of applied psychology. The admitting officer must never forget that the patient is the most important person, and guest of the hospital, and the simple fact that he requires hospitalization bespeaks his need for sympathy and consideration. The guest is not well, and will react quite differently to approaches and stimuli which, if encountered while in his normal state, would probably evoke no annoyance.

We must provide an admitting officer and an admitting office wherein may be secured in privacy and with the minimum burden to the patient an accurate assemblage of personal, social and economic detail which should automatically determine whether or not the patient should be full-pay, part-pay, etc., or whether the hospital would be justified in requiring that he seek municipal assistance to sponsor his hospital treatment. Too often we fail to get a picture of the debt the patient is already burdened with. He may be in debt to an extent that even though he earns a moderate wage, he cannot raise sufficient money to pay his hospital bill. If he has dependents we should know something of his home expenses and his ability to retrieve enough from income to meet the costs of hospital treatment. Most people will readily promise to pledge their future earnings with little thought to the problem involved. If the patient requires credit, there should be a definite written understanding as to the nature of his pledges and other promises to pay later. This will avoid certain unpleasantness when attempts are made to realize on the pledges made. The amount of his periodic payments should be consistent with his resources plus all contributing factors.

Investigating Ability to Pay

With the exception of accident or emergency cases, the average patient has been booked for accommodation by a member of the medical staff. As a rule the doctor will volunteer such information as he may have concerning the patient and will usually request a bed in line with his judgment as to what the patient can afford. Also there is usually opportunity to investigate the patient before he appears and form an opinion which is of considerable assistance during the actual interview in the admitting office.

It is advantageous to get a report on the patient from the local credit bureau, to which every hospital should subscribe. This may be discreetly done before the patient arrives, and should the patient come from out-of-town there are cautious ways and means of learning what one can about them. A tax assessment office, or a reliable merchant or other person with first-hand knowledge of the patient's reputation in a community, will yield helpful information. Possible hospital records of a previous admission will reveal much, although the entire picture has changed so rapidly, especially since the depression, that it is best to acquire a stream-lined 1937 report. It is more difficult to judiciously estimate the assets of patients in agricultural pursuits. To do so requires a complete picture of encumbrances including mortgages, both chattel and otherwise, and since 1934 we have found that refuge for many delinquent tillers of the soil, The Farmers' Creditors' Arrangement Act, responsible for many vexatious suspensions of payments. Debt adjustment and moratorium legislation such as the one cited present a difficult problem to hospitals serving wide rural areas, and most of our Maritime hospitals are in that category.

If the hospital requires that the patient provide a guarantor, he should be a person acceptable to the hospital, and not someone in as precarious a financial situation as the patient. If a promise to pay at periodic intervals is given, or a promissory note offered to cover prospective indebtedness, such memoranda of agreements should be a permanent part of the admission record.

Should the patient be able to pay at the time of discharge from hospital, it must be noted whether he desires to pay at the end of each week or all at one time. It is also important to ask whether the account is to be submitted direct to the patient or delivered to an authorized friend or relative.

There are always instances when a patient is of such obvious financial worth that all preliminaries are superflous and contribute nothing to the effectiveness of collection from him, who, as a rule, is a person who prefers to relegate such transactions to his secretary or other employee. There must always be obvious exceptions to every rule to avoid incurring an unnecessarily antagonistic and unfriendly attitude toward the administration of the hospital.

Protecting the Account

As we have mentioned above, the procedure indicated in an attempt to secure the patient's account will be modified by the skill with which it was handled in the admitting office, and the extent to which the hospital should go in enforcing payments when the patient is admitted as full-pay or part-pay is largely determined by the information accumulated at that time. (a) Demanding payment in advance is always a wise precaution, although as a rule it provides for only a short period of the patient's hospitalization and unless some other definite form of settlement is arranged when advance payment is secured it merely postpones the efforts to obtain payment. Here again we must warn against over-enthusiasm in the case of a gilt-

edge risk. It does more harm than good. It is acknowledged, however, that the ideal method of disposing of an account is to obtain continuous payments in advance throughout the stay of the patient. (b) A guarantor should always be demanded when an account is doubtful, with the reservation that the guarantor must be an established good credit risk. Every hospital should be a member of the local credit bureau, also it is good practice to subscribe to Dun's Bulletin, which publishes a week-by-week continuity of property transfers, mortgages, judgments, and other transactions pertinent to our work. (c) A note or other security such as an order on salary, insurance allowances, or other sources of the patients income, should invariably be required unless the hospital has made another form of settlement, or unless by so doing the hospital forfeits eventual claims for recovering from other sources such as municipalities, which in certain instances have repudiated liability on the ground that by accepting the patient's personal note or promise it was a tacit acknowledgment that the patient might not be indigent. This has occurred in instances where an injured person has received emergency treatment and given his note, and later investigation had proven his total inability to take it up. The argument is that the hospital was paid by accepting the note and that it is now the hospital's problem to realize on the paper. This can happen in instances where time does not permit investigation and the hospital desires to obtain some form of settlement. Like many provisions for good it can also prove itself a dangerous adversary.

Obtain a Written Acknowledgment

An effort should always be made to secure an endorsement. This is sometimes practically impossible of accomplishment. It is usually a wise precaution when a patient owns no real property but carries life insurance to obtain the beneficiaries' written acknowledgment of liability for the debt, as otherwise the patient in case of death would leave no other form of estate and the account would be uncollectible from the beneficiary, as we all know to our sorrow. We might comment that this is often met with in the case of railway employees, whose beneficiaries have been known to refuse to pay. It is usually safer to obtain an order on salary from a salaried man if he possesses no property with the understanding that it will be filed with his employer should he default in his payments. Unfortunately, none of these precautions are of great value unless the employer or other interested persons co-operate. In Moncton, the major industry is railroading, and the railroad will not permit an employee's salary to be garnisheed. Usually the intercession of a prominent official is sought to use discretionary pressure on the offending employee. Should a patient resort to legal devices such as bankruptcy or a farmer seek the shelter of the Farmers' Creditors' Arrangement Act, we must face the situation as it arises. I might say that we have fought several such attempts with a degree of success, but the expense involved as well as the annoyance is hardly worth the trouble. (d) It is always justifiable to warn of a possible transfer to lower priced accommodation such as part-pay or public ward should reasonable attempts to secure payments as agreed upon repeatedly fail. Usually the threat of contemplated transfer will bring about a satisfactory settlement, but there are instances when the dictates of good judgment justify a transfer to lower-priced or ward accommodation despite the protests or efforts of the patient and relatives to prevent such action. Such a decision is usually based on definite information in the hands of the credit department.

A Well Organized Department is Essential

It is advisable to have a separate credit department. Smaller institutions cannot afford the overhead of an equipped separate office, but it is possible to invest one responsible officer with the functions of a credit department, even though the officer is not located in a separate office. If the hospital can afford to have the services of an attorney working from the hospital it will be found to be a good investment, because a legal letter signed by an attorney will bring results when everything else fails. We may conclude, therefore, that there may be in every institution a credit department, whether it may be a mere walking delegate or the incumbent of a separate office. The credit officer should have a set-up calculated to bring about consistent results. The account should be arranged on admission, the strings tied up at discharge and all necessary papers and guarantees aranged (it is essential here that due notice be given from the floors of a contemplated discharge to facilitate preparation of necessary papers with the least amount of annoyance to the patient). The credit officer should then employ a consistent follow-up of notices and letters, and, if possible, interview the patient or his sponsor. Only after exhausting every channel of endeavor should he relinquish the duty to a solicitor. It is important to emphasize at this point that no matter what the content of an interview might be, always end it agreeably and amiably, regardless of what may have just passed between the debtor and the officer.

When there seems to be no alternative but to force collection, the hospital should have no compunction about seeking legal aid to recover a collectible account. If the hospital fails to perform this duty of making it obligatory for reluctant debtors to pay when they are in a position to do so, the costs go into current expenses and increases the charges against the other patients. It must not be forgotten that the hospital is using public funds, and that it is only the temporary repository of monies passing through its hands for the general benefit of the public as a whole. No one individual has the right to impose upon those funds.

In conclusion, we believe that the hospital owes it to the public to follow up every cent known to be collectible, even though it may include the retention of a solicitor and a judgment summons when all else fails. Failure to realize on a judgment summons should end the matter and the account should be written off. No person should be apprehended and imprisoned for a hospital debt unless there are most extraordinary contributing circumstances.

I would like to pay tribute to the work done by the Canadian Hospital Council in respect to business methods, and would recommend Bulletins, No. 14 and 15, which may be obtained from the Toronto office (184 College Street), and which after a careful study of their contents will yield the fullest measure of wise advice.

Presented at the Hospital Conference of the Halifax Meeting of the American College of Surgeons, 1937.

HOSPITAL LEGISLATION

PART II.

By

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Canadian Hospital Council

Recognition of Extra Provincial Responsibility for Care of Indigents

British Columbia—Reciprocal Arrangement: In 1936 the Hospital Act was amended to pave the way for a reciprocal arrangement with other provinces for the care of indigent patients in the reciprocating province. Section 31-A (1) now provides that a person domiciled in British Columbia, treated as a public ward patient in a public hospital of another province, and who is unable to pay, shall have paid for him to that hospital a sum not exceeding $2.00 for each day's treatment. This arrangement is dependent upon the provisions by such other provinces of similar arrangements recognizing responsibility for the hospitalization of their residents in British Columbia hospitals."

Saskatchewan: In 1936 the Local Improvement Districts' Relief Act was amended whereby the Minister may make advances by way of loan to settlers resident in local improvement districts, or in rural municipalities, for medical and hospital care and treatment, such loan to be a charge on the property of the person to whom it is made.

Notwithstanding anything contained in this or in any other Act, the Minister of Municipal Affairs shall have and be deemed always to have had authority to make provision for the medical and hospital care and treatment of any indigent person.

Whenever any expenditures are made by the Minister for or in connection with medical or hospital care and treatment of an indigent person who is a resident of a municipality, the Minister may recover from the municipality, by action at law, the amount of all such expenditures.

Legislation Governing the Care of Convalescent Patients

Ontario—Amendments to the "Public Hospital Act" in 1936: The municipal payment for a patient in a convalescent hospital was increased from 90 cents to $1.25 per day, and the provincial aid was increased from 30 cents to 40 cents per day.

"A convalescent patient" shall mean a person recovering from any surgical procedure, from exhaustive illness, from an exacerbation of a chronic debility, or from any infection which results in weakness, emaciation or anaemia, but shall not include patients recovering from any of the acute or chronic communicable diseases, unless it has been shown that such patients are no longer carriers of communicable disease, and shall include: patients requiring treatment after surgical procedures; patients suffering from orthopedic disabilities, or disabilities as the result of cardio vascular disease; patients requiring treatment for metabolic diseases, or chronic non-communicable respiratory diseases.

"Convalescent Hospital" shall mean any institution, building or other premises or place for the treatment of convalescent patients which is under the management and control of, or is affiliated with, any institution which is an approved hospital.

Unless the Minister consents in writing, patients shall be admitted to a convalescent hospital from and only after a period of treatment in an approved hospital or the out-patient department of such a hospital.

Compensation to Hospitals and Doctors for Care of Traffic and Other Accidents

Alberta—Traffic Accidents: Dr. Bow writes: "I understand provision was made by an amendment to the Vehicles Act at the 1936 session of the Legislature, by which drivers of motor vehicles are each required to pay a driver's license of one dollar and to renew the same annually. It is, I understand, proposed that part of the revenue obtained will be utilized to compensate doctors and hospitals for the treatment of persons injured in highway accidents."

Workmen's Compensation Arrangements

Nova Scotia—Workmen's Compensation Act Amended: In 1937, Bill No. 125 amended the Workmen's Compensation Act, providing for medical aid consisting of medical, surgical, dental, hospital and nursing services for a period of not longer than 30 days. The Board is given authority, however, to authorize such medical aid as may be necessary in addition to 30 days. Fees to be paid are to conform to the prevailing fees of the community as would be paid by the workman himself.

Miscellaneous Legislation

British Columbia—Standards of Care, Etc.: The Hospital Act was revised to provide the Lieutenant-Governor-in-Council certain powers with respect to the requiring from the hospitals of certain standards of care, the keeping of adequate books, records, and accounts as prescribed, and the maintenance of a satisfactory system of business administration. Hospitals may also be required to furnish satisfactory medical certification when requested, to justify the need of any patient for hospital care.

Alberta—Expectant Mothers: For the purposes of this section, an expectant mother applying for admission to hospital and certified by the attending physician as requiring hospitalization, shall be considered to be a case of sudden and urgent necessity.

Amendment to the Public Health Act, 1936, re Radium: No person shall use for the therapeutic treatment of human beings, any radium or radon, or any derivatives of radium, unless such person is the holder of a certificate issued by the Senate of the University of Alberta, certifying that he is qualified so to use the same.

Saskatchewan—Cancer: The various Municipal Acts provide that cancer cases requiring hospital treatment shall be deemed emergency cases.

Mental Hygiene Act: In 1936 the Mental Diseases Act and the Mental Defectives Act were repealed, and the "Act Respecting Mentally Defective and Mentally Ill Persons" was passed.

Manitoba: The Hospital Aids' Act was amended in 1937 by striking out the word "Minister" in several instances and substituting therefor the words "Municipal Commissioner."

Quebec—Ministry of Health: In October, 1936, at a special session of the Quebec Government, a Ministry of Health was established. Previously questions concerning Hygiene, Health, Public Charities, Insane Asylums, were under the Secretary of the Province.

This new "Law of the Department of Health", Provides for a Minister of Health. Dr. J. H. A. Paquette is the new Minister of Health.

The assignments, duties and powers of the Minister of Health are to supervise the administration or the enforcement, as the case may be, of the laws connected with the following:

(a) Hygiene and Public Health.
(b) Public Assistance.
(c) The Aliens.
(d) The inspection of hospitals and other charitable institutions.

New Legislation

Saskatchewan—Superannuation for Hospital Employees, Saskatchewan Tuberculosis Sanatoria Superannuation Act, 1935: This Act does not appear to have been mentioned in the 1933 or 1935 reports of the Legislation Committee. The provisions of this Act briefly are as follows:

An employee is one permanently employed by the Anti-Tuberculosis League.

The age of retirement is 65 for males and 60 for females, or after 35 years of service an employee may be retired on superannuation at the age of 60 for males and 55 for females.

The Superannuation Board has power to extend the superannuation period for a term of five years.

An employee contributes 4% of his monthly salary towards the Superannuation Fund, but does not contribute longer than 35 years.

Superannuation is granted to employees who have attained the age of retirement and have served 10 years continuously, or after 10 years continuous service if they are required to retire on account of ill health or physical or mental incapacity.

The superannuation allowance is calculated on the average yearly salary, by taking 1/50 of this and multiplying it by the years of service, the maximum superannuation being $2,000 and the minimum being $360 per year.

The Act came into force on March 1st, 1935, and any one who had been in the service for 10 years any time between March 1st and September 1st, 1935, and had reached the age of retirement, was entitled to receive annually one-half his salary, but not in excess of $2,000 per year, and this to be subject to a deduction of 4% of his last annual salary.

A person who had been in the service less than 10 years and who had reached the age of retirement on March 1st, 1935, would be entitled to a lump sum equal to one-tenth his annual salary multiplied by the number of years' service.

If the superannuate dies and leaves a widow, or widow and children, one-half the allowance he was entitled to would be paid to the widow for life, or until re-marriage; and to each child under 18 years, and until that age was reached, a sum equal to 10% of the allowance, the total paid to the children not to exceed one-quarter of the allowance, and to be divided among them. If the wife predeceased the superannuate or re-married, her half of the allowance would then go to the children under 18 years of age.

If an employee dies after 10 years' service a similar arrangement to the above exists as to payment to the wife and children.

If an employee dies before 10 years of service a lump sum is paid to the wife or children, if any, not exceeding his total contributions with interest at 3%.

If an employee retires voluntarily, or is dismissed, he shall be refunded the amount of his contributions to the fund.

Payment is made from the Superannuation Fund, and if there is insufficient in the fund the deficit is met by payments from the revenues of the League.

If an employee receives compensation from the Workmen's Compensation Board, or any such Act, or as a result of the same injury becomes entitled to payment under the Sanatoria Superannuation Act, he would be entitled to receive the amount, if any, by which the amount he would otherwise be entitled to receive under the Superannuation Act exceeds the amount he receives from the Workmen's Compensation Board, but no more.

New Brunswick—Mental Hygiene: In 1936 New Brunswick passed the Provincial Hospital Act (Mental Diseases), and it was brought into force by proclamation in December, 1936. It is to be administered by the Department of Public Health.

Included in the definitions of terms used in the Act are the following:

"Approved Home" shall mean a home to which patients may be released from the hospital in the manner provided under the Act and Regulations.

"Habitue" shall mean an alcoholic or drug habitue or addict.

"Mental Defective" and "mentally defective person" shall mean a person in whom there is a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by diseases or injury, and who requires care, supervision and control for his own protection or welfare or for the protection of others.

"Mental deficiency" shall mean the condition of mind of a mental defective.

"Mentally ill person" shall mean a person other than a mental defective who is suffering from such a disorder of the mind that such person requires care, supervision and control for his own protection or for the protection of others.

"Mental illness" shall mean the condition of mind of a mentally ill person.

"Settlement" shall mean a legal settlement as provided for in the Act respecting Settlement of the Poor.

Included in the powers to make regulations are the following:

Granting certificates of approval to "approved homes"

and the fees payable therefor, and withdrawing such certificates.

Fixing the situation, construction and equipment of approved homes.

Prescribing the charges which shall be paid for the maintenance of patients in the hospital.

Prescribing the amounts to be paid for the care and maintenance of patients who are in an "approved home."

The Superintendent shall be appointed by Order-in-Council and shall be a physician with special training in psychiatry and hospital administration.

All actions and prosecutions against any person for anything done, or omitted to be done, in pursuance of this Act, shall be commenced within six months after the Act or omission complained of has been committed and not afterwards.

Where the Superintendent reports to the Minister that any patient in the hospital requires hospital treatment which cannot be supplied therein, the Minister shall, if otherwise permitted by law, have authority to transfer such patient to a public hospital for treatment which cannot be supplied in the hospital.

Any person who is mentally ill or an habitue may be admitted to the hospital as a voluntary patient.

Any person who is, or is believed to be, in need of observation, care and treatment provided in the hospital, may be admitted thereto as a patient for observation.

Any person who is mentally ill or mentally defective, or an habitue, may be admitted to the hospital as:

(a) A patient for observation.
(b) A certified patient.
(c) An Attorney-General's warrant patient.
(d) A patient remanded by a judge or a magistrate in accordance with the provisions of this Act and the Regulations.
(e) A patient under Judge's finding as an habitue.

No person may be admitted as a voluntary patient who is:

(a) A person suffering from mental illness or infirmity due to old age, or from incurable disease, for which general hospital or other institutional care is required.
(b) A mentally defective.

On the certificate of a physician, the Superintendent may receive and detain in the hospital a patient for observation, for a period not exceeding 60 days. Certified patients shall be admitted to the hospital only upon the prescribing certificate of two physicians.

Upon it appearing to the Minister that any mentally ill, mentally defective or epileptic patient detained in the hospital has come or has been brought into New Brunswick from elsewhere within sixty days prior to his admission to such hospital, the Minister shall take the necessary action to have such patient removed to the province or country from which he has come or been brought.

A patient released on probation to his family or friends may be apprehended and brought back on warrant from the Superintendent, if such is found necessary, any time within twelve months from such release.

Approved Home: The Minister may issue a certificate approving of any building, premises or place as an approved home for the reception of patients who may be released from the hospital into the custody of such home and entitling any person to receive into the approved home one or more patients.

If the mental condition is due to senility and the patient is quiet and harmless, he may be discharged from the hospital and placed in a municipal home in the county in which he had a settlement.

Habitues: The Superintendent may receive in the hospital, detain therein, care for and treat as a patient, any habitue who voluntarily makes written application on the prescribed form for habitues, provided that, in the opinion of the Superintendent, he is, at the time of his admission, capable of appreciating the fact that he is to be admitted as a voluntary patient.

Such patient shall not be detained in the hospital longer than one year.

On petition made by a relative, or friend of the alleged habitue, or by the family physician, to a judge of the Supreme Court, he shall inquire into allegations set forth in the petition.

The petition may set forth that the alleged habitue is so given over to the use of alcohol or drugs that, (A) he is unable to control himself; or is incapable of managing his affairs; or squanders or mismanages his property; or places his family in danger or distress; or transacts his business prejudicially to the interests of his family or his creditors; or, (B) that he uses drugs or intoxicating liquors to such an extent as to render him dangerous to himself or others; or incur the danger of ruining his health and shortening his life thereby.

The judge shall report his findings, if positive, to the Superintendent, who may, by warrant, direct the removal of the habitue to the hospital to be placed under treatment and detained therein for a period not exceeding two years.

Any person who is suffering from the effects of alcohol or drugs may be admitted to the hospital and detained therein for a period not to exceed 60 days, on the certificate of two physicians.

The patient cannot be admitted except within seven days of examination.

The Superintendent shall have full authority to discharge an habitue when, in the opinion of the Superintendent, he is sufficiently recovered, or it is in the interest of such patient or of the hospital that he be discharged; or if default is made in payment of his maintenance.

Liability of Municipalities: The costs and expenses in determining the mental condition of any person, including five dollars to the examining physician, and ten cents per mile travelling expenses, and the expense, incurred in conveying such person to and from the hospital, shall be paid by the municipality from which the patient comes.

Where such patient is not destitute the costs and expenses may be recovered by the municipality from the patient or his estate.

Any patient admitted to the hospital, who has at the time of his admission or subsequently come into possession of any property, shall be liable for his maintenance.

The rates for the maintenance of patients which shall be chargeable to the municipalities shall not exceed five dollars per week for each patient.

Health Insurance as it Affects Hospitals

British Columbia: The Health Insurance Act of 1936 was not brought into force. In 1937 a plebiscite was put

to the electorate as follows:

"Are you in favor of a comprehensive scheme of Health Insurance progressively applied?" The result of the vote was in the affirmative.

Federal Legislation

Unemployment Insurance: The Employment and Social Insurance Act of 1935 was found to be invalid. In this Act the list of excepted employments included: "Employment as a professional nurse for the sick or as a probationer undergoing training for employment as such nurse."

Minimum Wages Act: The Minimum Wages Act of 1935 was declared ultra vires.

Weekly Rest in Industrial Undertakings Act: The Weekly Rest in Industrial Undertakings Act of 1935 was declared ultra vires.

Limitation of Hours of Work Act: The limitation of Hours of Work Act of 1935 was declared ultra vires.

Sick Mariners: The tendency of late years has been to close certain Federal Marine Hospitals, and to make arrangements with provincial public hospitals to do the marine work for a certain stipulated price per day.

Farmers' Creditors' Arrangement Act and Hospitals: This Federal Act, passed in 1934, provides that a farmer unable to meet his liabilities as they become due, may make a proposal under this Act "for a composition, extension of time or scheme of arrangement, either before or after an assignment has been made." On the filing with the official Receiver of a proposal, no creditor, whether secured or unsecured, shall have any remedy against the debtor, or shall commence or continue any action, execution or other procedure for the recovery of a debt unless with leave of the Court and on such terms as the Court may impose. Hospitals are not listed as preferred or secured creditors, and where this Act is invoked hospitals cannot collect their accounts or are asked to accept an unsatisfactory bases of payment.

Hospitals and provincial hospital associations have requested the Canadian Hospital Council to make application on their behalf to Ottawa, that the Farmers' Creditors' Arrangement Act be so amended as to exempt the debts due the hospitals, by patients, from the provisions of this Act, or at least placed in a more favored or secured position than they are at the present time.

The Canadian Hospital Council, therefore, took this matter up with the Minister of Finance, and the following sympathetic reply was received from the Administrator of the Act:

"Department of Finance, Canada,
Ottawa, April 22, 1936.

Dear Dr. Agnew:

Your communication of the 20th instant, addressed to the Honourable Minister of Finance, has been referred to me, relative to the disadvantage under which Canadian hospitals may be placed attributable to the manner in which proposals submitted by farmers under the Farmers' Creditors' Arrangement Act are dealt with by the Provincial Board of Review.

The splendid services afforded to farmers throughout Canada by hospitals are fully recognized, not only by myself but by the Judges who act as chairmen of these Boards and the individual members of such Boards.

In this connection, I may point out that it is only the farmer who is insolvent to a degree at least that he is unable to meet his liabilities as they fall due, who is entitled to submit a proposal under the Farmers' Creditors' Arrangement Act. Reductions in such farmers' debts are made only where such action becomes necessary to bring the farmer's obligations within his present and prospective capacity to pay.

All Boards of Review recognize the degree of priority or preference to which an hospital account is entitled beyond that consideration which may be given to other types of unsecured debts, particularly the obligations assumed by farmers for non-essentials or for luxuries.

The situation with respect to this question at the moment is simply this: the Farmers' Creditors' Arrangement Act is the subject of reference to the Supreme Court of Canada, with respect to the question of its validity. Should the Act be upheld it is the intention that prompt consideration will be given to such amendments as may be necessary to the Act itself and to the Regulations thereunder, at which time further and very careful consideration will be given to the representations submitted by you on behalf of the Canadian Hospital Council.

In the meantime, I am taking the liberty of forwarding a copy of your letter to all Boards of Review throughout Canada in order that the serious import of the situation may be given further consideration by them in dealing with present and future sittings of the Boards.

Yours very truly,
(Sgd.) H. F. Gordon.

In reference to the second last paragraph of the above letter, this Act has been declared valid.

The Excise Act and Hospitals

By an Order-in-Council, April 8th, 1937, a "Bona fide Hospital", under the Excise Act, and a "Bona fide Public Hospital", under the Special War Revenue Act, is defined.

"Chemical Stills: Section 136 of the Excise Act, 1934, was amended April, 1937, to provide exemption from the license fee for chemical stills in the possession of bona fide hospitals, duly certified as such by the Department of Pensions and National Health."

Sales Tax

The Amendment to the Special War Revenue Act passed in 1936 provides that:

Sales Tax is changed from 6% to 8%.

Liver extract for use exclusively in the treatment of anaemia is exempt from the Sales Tax (206a).

Also, chairs and tables for surgical operating purposes, and complete parts thereof: infant incubators and complete parts thereof; electro-cardiographs and complete parts thereof, and sensitized film and paper for use therein (476a).

"The Department holds that sales of taxable articles and materials to bona fide public hospitals are exempt from Sales Tax, provided an authorized official of the public hospital certifies on the purchase orders that the goods are for the sole use of the hosptial and not for the purpose of resale. Likewise, public hospitals are permitted to import articles and materials without payment of the Sales Tax, provided the certificate is endorsed on the customs entry when the hospital enters the goods for consumption in Canada."

Obiter Dicta

INTERNSHIPS

FROM time to time "The Canadian Hospital" has discussed the problem of intern training as it affects hospitals; this has been both editorially and in our articles. We are again stimulated to discuss the matter by the recent publication of the Joint Committee report on "Intern Education and Supervision", sponsored by the Canadian Medical and Allied Associations.

Although it goes without saying that considerable progress has been made in recent years by our hospitals in providing reasonable facilities for intern training it is apparent from this report that as yet there are hospitals who are accepting interns but not fully shouldering the responsibilities of intern training, at least, not in a properly organized and rounded out manner. It may be, of course, that the training is being carried out but that proper statistics are not being kept thus making it impossible to estimate the efficiency or otherwise of their curricula. An outstanding hospital administrator once remarked that as yet hospitals have not fully realized the difference between utilizing the services of interns in a proper manner and using them as errand boys for the medical and nursing staffs. Perhaps this statement is true, at least to a certain extent to-day. It is relatively easy to publish a syllabus of intern training and invite interns to join the hospital staff but when it is realized that the year of training provided by the hospital may decide to a major extent the approach which the young doctor will have to the practice of medicine in his future life, it is obvious that the responsibility of the hospital and its medical staff is by no means a small one.

It is not suggested for one moment that the work done by the intern during his year should not be so arranged that it is of maximum benefit to the hospital but it must not be so planned without providing equivalent benefits for the intern. Briefly, the hospital must so organize its medical staff that they will plan an organized form of bedside teaching, discuss the various procedures with the intern instead of leaving him to find out as best he may why and how different things are done. The staff must review case histories written by the intern and from their knowledge and experience point out the right and wrong of the intern's observations. It is vital that a proper record of the intern's work be kept because this will most probably be required on his behalf when he makes application to other institutions for an appointment and his inability, through the hospital's delinquency, in not being able to provide such information may seriously affect his chances of securing such appointment.

Many other matters have to be considered and they are clearly pointed out in this joint study. They include such problems as the legal status of interns, supervision, honorariums, co-relationship of various hospital departments such as the nursing service, orderly service, etc., with intern training. Library facilities and ethics are other important considerations. All of these very definitely point to the fact that the hospital cannot lightly accept interns and feel that if they provide suitable quarters, uniforms, and a small salary, they have performed their part of the contract. Conversely, if the hospital does enter sincerely into intern training then it has every right to expect the fullest co-operation from the different Medical Schools in the selection of interns of high standing who will bring credit to the hospital and a sense of mutuality which is vital to both.

Reducing Competition

ONE of our Canadian hospital administrators has for some time been expounding a plan which he believes would do a great deal towards the elimination of the competitive spirit which periodically arises between hospitals situated in the same community. He feels there is evidence to show that when two or more hospitals are in the same community there is a tendency for them to duplicate each other's equipment and services to a relatively marked degree, and whereas it is stressed that of necessity considerable duplication must take place, there is no doubt that with suitable understanding between the hospitals a division of certain facilities and equipment would redound to an increase in patient service, a saving of money, and the automatic elimination of competition.

To emphasize this argument the following example is given. Two general hospitals of similar type both develop elaborate maternity departments, and, speaking frankly, compete against one another for clientele. If one attempts to improve the service the other hospital follows suit, yet these same hospitals because they are not particularly interested in, say, urological and paediatric service, provide only fair service and equipment and these sections in each hospital are of minimum standard. Now if one hospital would concentrate on the obstetrical service, the other on, for instance, the urological service, adequate facilities for the treatment of both classes of patients would be available to the community. There would be no duplication and the spirit of competition would be eliminated.

This argument seems relatively sound to us providing the disadvantages are realized at the outset. On the sur-

face it would appear that the advantages outnumber the disadvantages. Patients may at first have a preference for one hospital but when they realize the benefits derived from such division of services any prejudice they may have would disappear. This would broaden community relationships between the hospitals and because of the lack of competition there is very little doubt but that the relationship between the hospitals themselves would be much closer which is a condition to be greatly desired.

While editorially we do not feel like expressing an opinion as to the practicability of the above suggestions we are convinced that this subject has sufficient value and interest to be presented to our readers and we welcome comments through the pages of "The Canadian Hospital" relative to the theme of this plan.

The Determination of Departmental and Service Costs

The United Hospital Fund of New York, through its conference on Hospital Accounting, has published a book entitled "Procedure for Hospital Costs", and prepared by William A. Dawson, Consulting Accountant to the United Hospital Fund of New York. The purpose of this book is to assist in the setting up of forms and procedures which will permit accurate financial information with respect to the operating and other costs of hospital departments and services. It is a practical work and many tables and forms are included to illustrate the procedures described. For the purpose of showing that any size or type of hospital can apply this procedure, a hypothetical hospital using only a cash-book and recording few statistics is used as an illustration. It is stated that the method can be applied by any hospital, the more complete the records the less the work. The book is priced at $1.00.

The Scope and Functions of the Advisor to Schools for Nurses

(Continued from page 16)

Then we must consider the Advisor and her responsibilities in connection with the examinations for the registration of nurses? Is the criticism that is often so justly levelled at these, a reflection upon her administration? What part has she been called upon to play in their preparation? Recognizing that the Board of Examiners must be a group with very special preparation for the educational function they assume, the Advisor's influence should also be used to bring into proper relationship, conditions in school, community and professional needs, and the responsibility of the members in connection with these. If such examinations are not to become a perfunctory method of discrimination, someone must concentrate upon the necessity for constant study and change, upon readjustments, and adaptations, to bring them in line with modern advancements. With the raising of standards in other provinces, and the increasing emphasis that is being placed upon registration, we must protect our nurses, and preserve for them the privileges of reciprocal registration. University support and direction should lend prestige and strength, but it does not relieve a profession of its continuous obligations to its members and to the public.

Workmen's Compensation Board Regulations as Applied to the Hospital

By
D. J. GALBRAITH, M.D.,
Commissioner, The Workmen's Compensation Board,
Toronto, Ontario

TO the members of the Ontario Hospital Association it may seem unnecessary to point out the important place occupied by the Workmen's Compensation Act in the field of social legislation in this Province or to discuss its tremendous importance to you as hospital officials. However, as we find that most people, whether workmen, employers or others affected by its provisions are surprisingly unfamiliar with its functions, powers and limitations, I propose to outline briefly its set-up and more important achievements.

While this paper, given by Dr. Galbraith before the Ontario Hospital Association, deals primarily with the Ontario Workmen's Compensation Board problems we feel that the experiences in all Provinces are sufficiently similar to make the article of general interest to all hospital workers.

Functioning since 1915 the Board have during that time investigated and cared for over one and a quarter million accidents, have collected and distributed over $120,000,000, have paid out for the care of these cases to the surgeons, nurses and hospitals, over $18,000,000 and are at present handling well over three hundred new accidents each working day. You can understand how important to us of the Board is the continued and ever increasing co-operation of the hospitals and how much we appreciate this opportunity to discuss some of our common problems.

Under this Act most industries in the Province are required by law to contribute to the accident fund. These industries are grouped into classes according to the nature of their work and the risks and hazards of the industry. The amount that each employer is required to contribute is determined by the accident cost or experience of his particular class or group for the preceding years and is collected in much the same way as taxes by an assessment on the audited payroll of the firm. In this way the Board have funds available provided by the employers of labour, not by the Government as so many seem to believe—from which to pay compensation to the injured workman for his loss of wages—not damages for his injuries—and the necessary cost of treatment.

The section of the Act which governs most of our mutual relations—Section 49—is very clearly stated, easily understood, and should not be readily misinterpreted. A copy of the Act or at least this section dealing with medical aid should be in every Medical Superintendent's desk. Briefly, from your standpoint it provides that the injured workman shall be entitled among other things to "such hospital and skilled nursing services as may be necessary as a result of the injury", "that all questions as to the necessity, character, and sufficiency of any medical aid furnished shall be determined by the Board" and "the fees or charges for such medical aid shall not be more than would be reasonably charged to the workman if himself paying the bill."

These very definite limitations on expenditure demonstrate to you why we are often unable to deal as kindly with your bills as our natural generosity may dictate.

On receiving an accident report from a workman or employer, the machinery is set in motion for paying the costs of the accident from the accident fund. These include compensation to the extent of two-thirds of the wages, provided the man is disabled for seven or more days, and the costs of medical aid. This is where you are concerned and, for the protection of your finances, must know the provisions of the Act.

Care must first be taken by the Board to ascertain that the disability is the result of an accident coming within the provisions of the Act, for as trustees of the employers' money we must be at all times in a position to show cause for the payments made. With this view, reports are required from three sources—the workman, employer and the surgeon. Should these reports agree, and they usually do, and the condition is clearly shown to be the result of an accident coming within the provisions of the Act, the claim is allowed. At this point and not before can we consider payment of compensation and medical aid.

We realize, of course, that you as hospital executives are anxious to know at the time of admission whether the Board will accept responsibility for a case. While you can be reasonably certain that a workman injured by an accident "arising out of and during the course of his employment" will be cared for, you cannot be positively assured. For instance, a man working in a sawmill comes in contact with a saw and loses his hand. If he is the owner of the mill or a director, he may not be required by law to be covered, or if he is the son of the employer and his wages not reported as such, his claim may not be allowed. We cannot allow the claim if his wages have not been reported and assessed upon and you must look elsewhere for the payment of your bill. Until all reports are filed and examined we cannot pass upon the claim or advise you

definitely as to the status of the account. This is unfortunate for you but seems necessary for the protection of the other members of the employment group who could hardly be expected to pay accounts for workmen whose wages were not included in the payrolls of their competitors.

In a general sense, however, when a workman injured at work is brought to a hospital, it is a Workmen's Compensation Board case. To what extent then, is the Board responsible in these cases? As pointed out before, the Act states that the injured workman is entitled to "such hospital and skilled nursing services as may be necessary as a result of the injury." At the first enforcement of the Act the Board had to so arrange that the injured workman should receive all the benefits to which he was entitled and yet assure itself that the provisions of the Act should not be abused. The Board had been given authority to arrange for the necessary medical aid and considered for a time designating certain specified hospitals at various points throughout the Province to which alone compensation cases might be sent. The appointment of certain surgeons as solely authorized to attend compensation cases was also considered. This, as you know, is the plan adopted by the insurance companies. But this course was not followed. It was felt that in the enforcement of the Act—our first distinct forward step in social legislation—it should be so administered as to benefit as many as possible. It was, therefore, decided that every qualified medical practitioner in the Province and every licensed hospital—public or private—should be eligible to attend compensation cases. This arrangement was acclaimed by the medical profession and the hospitals and has worked out very satisfactorily. So long as it continues to do so the Board has no intention of making any change.

The Reason for Semi-private Accommodation

The first difficulty experienced was when it was decided that necessary hospitalization would mean public ward accommodation as at that time most accident cases from industrial plants were being admitted to the public ward. The physician in general practice, however, pointed out that in such a case he would be required to turn the claimant over to the staff surgeon in charge of the ward. In order, therefore, to permit the doctor called in attendance to follow his patient into the hospital, to remain in charge of the case, and be responsible to the Board for the progress reports, it was decided to authorize semi-private accommodation for all of our cases. A daily hospital rate was agreed upon to include all extras except X-ray examinations and the use of operating rooms. The story of the rate allowed at first and the present increased one, grants, etc., is interesting but would serve no purpose here. Suffice it to say that the present allowance is $3.00 per day and includes all extras except operating room for which $5.00 is paid and X-ray examinations at the Board's Schedule rate.

Provision for Extras

It should be observed that while the word "necessary" as used in the Act does very definitely limit the type of accommodation and treatment warranting payment by the Board yet we do interpret this to allow of many extras if they may hold out hope of alleviating the workman's

condition or the possibility of assisting in his recovery, even to the extent of private rooms, special nurses, consultations, or whatever may be suggested by those in charge of the patient as being in his best interests. In brief, we want our claimants to have the best you can give them, adequate, efficient, conscientious treatment but not luxurious service and for this we will gladly authorize payment. All extra requirements or expenses must, however, be explained to us during the course of the emergency and not long afterwards when presenting an increased bill.

Occasionally you will meet a patient who claims an intimate knowledge of the Workmen's Compensation Act who will demand his "rights" and may be noisy about it. While it is the hope and endeavour of the Board to provide for every injured workman all to which he is entitled under the Act and every worthwhile aid to his recovery, the hospital authorities on their part must be aware that the Board cannot pay beyond what is authorized by legislation.

Length of Hospitalization

A vexatious question, as vexatious to the Board as to the hospital authorities, is "How long is the patient allowed to remain in hospital at the expense of the Board?" This question has come up from some point or other in the Province every few months for the past twenty years and appears to be a serious problem to many hospital authorities. An officer of the Board was calling on a certain hospital not long ago and the question was asked. He suggested that where it was evident to the hospital staff that a patient was remaining in the hospital when he might reasonably be discharged to receive the balance of his treatment at his home or by attendance at the doctor's office, the matter should be taken up with the doctor. The Superintendent's reply to our officer was "Our hospital would prefer to accept any loss in revenue rather than speak to the doctors as we depend on them to keep our hospitals full." A hospital taking this attitude surely cannot complain of any necessary adjustments of its accounts. There is apparently only one answer to the question—that is, the Board can only be responsible for the period of hospitalization shown to be necessary by the reports on file with the Board.

Everyone connected with a hospital is familiar with the patient who does not wish to leave although his condition has reached the point where he might reasonably be discharged. The pleas that he has no money, that he has nowhere to go or that his home is in some distant town, do not constitute the necessity for hospital or skilled nursing services.

Quite recently a patient was instructed by the Board to call on a doctor in a nearby city. The surgeon advised and was authorized to arrange for physiotherapy treatment for the man's arm. Because the claimant came in from the country the doctor had him admitted to the hospital as a semi-private patient in order that he might receive one physiotherapy treatment daily. $21.00 a week is rather expensive room and board when the claimant could quite well have been accommodated in a boarding-house at approximately one-third of the cost. Should we authorize such needless expenditure, we could hardly be considered to be carefully administering our trust.

The Hospital Must Accept Certain Responsibility

The Board have always felt that the hospital authorities should assume a share of the responsibility for over-hospitalization and in most cases this added burden is accepted by the superintendents but, unfortunately, there are the exceptions and it is here that the difficult problems usually arise.

You must exercise some supervision of Workmen's Compensation Board claimants. Here is a case — we learned that one of our claimants, a case of fractured toe, had been walking about the hospital fully clothed, wearing his boots, for a period of two weeks. The case had apparently escaped the notice of the hospital officials. When the matter was brought to the attention of those in authority the man was promptly dismissed and the surgeon reprimanded—but who should pay the bill?

A man with a knee disability was placed in a hospital recently and certain palliative treatment recommended; then the doctor went away on vacation and said he advised the house surgeon to carry on; if the patient did not do well to try something else—whatever he thought best. Fomentations were still being used three weeks later when the case came to our attention. We were forced to transfer the claimant to another surgeon for an operation that should have been performed at least two weeks sooner. Two weeks' hospitalization, two weeks' compensation lost, but most important of all, the claimant's disability unduly prolonged and he and his family subjected to needless suffering and suspense! In such a case we assess a part of the bill directly to the surgeon because obviously the claimant should not be penalized and industry cannot be held responsible. Here, the Hospital Superintendent is put in a most difficult position should he decide to interfere. But should he not at least call such cases to our attention?

In another city recently we found that a chronic case having spent many months in a hospital, was allowed to go home for varying periods, from week-ends to longer vacations, without any deduction being made in his account for these absences or the facts being reported to us.

It was to care for such conditions that our much discussed system of assignments was instituted. In many of these cases it is apparent that the claimant is not altogether responsible as he cannot effect his own discharge. Industry cannot be justly required to pay these unnecessary bills. The surgeon is at fault and the hospital authorities take no responsibility. Accordingly it has been considered that the fairest scheme we could devise was to arrange for the payments of boarding-house rates—$1.25 per day—on assignment by the patient to the hospital and in some cases an additional sum by the surgeon in charge. We appreciate that very often this scheme works an injustice to some of the parties concerned but it seems impossible to correct these conditions with absolute justice to all. But where each is willing to accept his full responsibility little trouble is encountered.

Before leaving the question of allowances we are often asked "Does the $3.00 per day cover all cases, even where a severe burn case is treated, involving extensive dressing and expensive drugs?" Our answer is that the hospital is expected to provide the usual treatment requirements but in unusually heavy cases particulars of the cost of supplies should be furnished and an additional allowance will be given careful consideration. We want to be fair to all.

The Method of Accounting

The accounting or bookkeeping end of your work is important. Our office procedure calls for an account form being sent to the hospital immediately on receipt of the information that the claimant has been admitted. When this information is received in the original report an account form is mailed the same day but should the notice be received from the hospital the account form might not be issued for a period of ten days. Receipt of the account form by the hospital does not guarantee payment of the account but it does indicate that the accident has been reported to the Board and that unless some unusual circumstances are present, the claim will be allowed and the account dealt with.

It is urged, and we are continually emphasizing the point, that the hospital submit their account to the Board at the end of each month dating from the claimant's admission. Some secretaries persist in sending accounts at the end of the calendar month. You can readily understand this is not practicable as it would mean that the Medical Aid Department would be deluged with accounts during the first few days of the month and would result in inevitable delay in payment. If a claimant is admitted on the eleventh of the month, the hospital should submit the first month's account on the eleventh of the following month. For various reasons it is not agreeable to the Board to have accounts submitted for two, three or four months' periods.

The Board is at all times glad to reply to inquiries and to assist the hospitals in keeping their records up to date. Unfortunately, however, some hospitals consider this service unlimited and make what we deem unreasonable requests: for instance, we recently received a list of outstanding accounts shown by the books of a certain hospital which covered two or three pages—scores of them—dating back for eight years. This list was received in spite of the fact that every six months or so previously the hospital had submitted what they stated was shown by their books as outstanding and we had regularly replied in detail regarding each case; usually, that the account had already been paid or the hospital had been advised as to the reasons which prevented our paying. Another hospital recently had an accountant called in and we were asked to pull scores of files and advise whether certain accounts had been paid and if not, the reason therefor. Our staff is limited and exceedingly hard-worked and surely they should not be asked to put in hours of overtime, work for which they receive no payment, in order to re-check massive lists of accounts due entirely to bad bookkeeping in the hospitals.

Within recent weeks the Board has made changes in the office routine which we hope will facilitate the handling of medical aid accounts and shorten the period between the receipt of account and the date on which the cheque is issued.

Your co-operation is earnestly sought in this regard as the Board is just as anxious to pay the account and dispose of the case as you are to receive payment.

Increasing Costs

Another of our problems, as well as yours, is increasing costs. As I mentioned before, there has been paid out for

the care of the injured workman under the Act, over $18,000,000 and this does not include cases coming under Schedule 2 where payment is made direct by the employer, usually after the accounts have been checked by our Medical Aid Department. It is safe to say that including these cases the payments under the provisions of the Act exceed $25,000,000 and are at present running over one and a quarter million dollars per year. These amounts are steadily increasing—roughly the proportion of medical aid costs to the cost of compensation in Schedule 1 has increased from around 15% in 1918 to over 30% in 1936. Little has been added in the way of treatment, chiefly dental aid and some industrial diseases. The employers who supply the funds are necessarily concerned at this situation and carefully scrutinize the payments made for their employees. They believe some accounts are needlessly high; that some patients are kept too long in hospital and that more X-rays are taken than the cases warrant. Some employers definitely state that bills rendered us from the hospital have been greater than has been charged to themselves, the employers, for the same service.

These are serious conditions and, fortunately, such cases are the rare exceptions. They did, however, exist in some X-ray departments and as they create so much bad feeling and are so hard to overcome, they are diligently searched out and if possible corrected.

We ask your help to eliminate all such conditions. Assist us in this as we are willing to assist you in your more burdensome and expensive cases and together we may be enabled to attain that for which we all should strive, to furnish adequate hospitalization to the injured workman at a cost which will not unnecessarily burden the industry of the Province.

Annual Reports

The Canadian Hospital Council would be very appreciative if hospitals throughout Canada would send to its Secretarial Office copies of their annual reports. The information contained in these reports is of considerable assistance in the work of the Secretarial Office, but, unfortunately, there are a great many gaps in the files of reports. In the case of those hospitals which do not issue a printed booklet, a carbon copy of the reports furnished to the Board or to the local press would be quite satisfactory.

Freeport Sanatorium Adds New Wing

The Freeport Sanatorium, near Kitchener, Ontario, has completed the erection of a $60,000 three-storey wing, accommodating 45 additional patients. This sanatorium has done excellent work under the direction of Doctor E. H. Coutts, and has needed this new addition for some time.

Chairman of Board Elected

Mr. C. N. Weber has been elected Chairman of the Kitchener-Waterloo Hospital Commission.

Brief Submitted to the Royal Commission on Federal-Provincial Relations by the Canadian Hospital Council

THE Executive Committee of the Canadian Hospital Council in January submitted the following Brief to the Royal Commission on Federal-Provincial Relations. National and other organizations have the privilege of submitting briefs to the Commission on various topics relating to public welfare and government; that of the Canadian Hospital Council dealt entirely with matters of hospitalization.

December the 29th, 1937.

Mr. Chairman and Members of The Royal Commission on Dominion-Provincial Relations, Ottawa, Canada.

Dear Sirs:

The Canadian Hospital Council respectfully desires to place before the Royal Commission on Dominion-Provincial Relations its views with respect to certain aspects of hospital work, which may be related to some of the problems of federal-provincial-municipal relationship likely to be considered by the Royal Commission.

As the Canadian Hospital Council represents all of the thirteen provincial and other hospital associations in Canada, it may rightly claim to represent the official viewpoint of the public hospitals of this country. The fact, that, in its membership, it also includes the departments of health of the federal government and the various provincial governments and also the Department of Hospital Service of the Canadian Medical Association, gives the Canadian Hospital Council a broad viewpoint.

Canada has an unusually fine system of hospitals, and it has been a matter of pride among those interested in humaritarian work that the poor are so well cared for, that they are housed and cared for in the same hospitals as are the well-to-do and that the full facilities of the hospitals, both in expert knowledge and in equipment, are available to all alike.

In view of the almost complete lack of endowment of all but a few hospitals, this service has only been possible through government and municipal aid, either in whole or in part—in whole for those institutions municipally owned and in part to the voluntary hospitals to supplement the generous though inadequate support of private charity, and the unselfish donation of service by the Medical Staffs, Religious Orders and other volunteer workers.

In any allocation or re-allocation of responsibility for the hospitalization of non-pay patients, we respectfully request that

(1) The necessity of ADEQUATE State assistance in the care of the poor be recognized; and that

(2) It be indicated on what basis this assistance be provided by the federal government, the provincial governments and the municipalities; and that

(3) The provision of this financial assistance be such as to cover the hospitalization not only of indigents or non-pay patients of fixed residence, but also of transients not coming under the residency requirements, of immigrants with less than three years' residence in Canada, of old age pensioners and their dependents, of "burnt-out" pensioners, of recipients of mothers' allowances, of the blind and such other groups concerning which responsibility for payment for hospital care is either not clear or not provided for at all.

Should unemployment insurance become a federal responsibility, provision should be made for meeting the full cost of hospitalizing the recipients of such insurance benefits.

Should relief be made a federal responsibility, it is respectfully urged that hospital and medical care be included under its provisions.

At the present time in many parts of Canada relief recipients continue to draw relief while hospitalized, but may make no contribution towards the hospital care received. It is strongly felt that, whenever and wherever any person at the time in receipt of unemployment or direct relief requires hospitalization for illness, such direct or unemployment relief should be so adjusted during the stay in hospital that a direct grant be made to the hospital caring for such patient equivalent to the cost of his hospital care in the public ward. It is urgently felt, moreover, that some responsibility should be assumed by one of the governmental units, provincial or federal, for adequate provision throughout Canada for the care of the incurable, the chronically ill or disabled and the aged. In this particular requirement, private philanthropy has not proven adequate for the task and voluntary effort should be supplemented.

Health Insurance

Should health insurance come under the purview of this Royal Commission, attention is called to the following Resolution on Health Insurance unanimously endorsed by the Canadian Hospital Council at its regular meeting last September. This fairly expresses the views of the hospital workers of Canada.

WHEREAS there would seem to be a definite trend in Canada towards governmental control and socialization of health services, or to what is known as "health insurance;"

AND WHEREAS this matter is of vital and paramount importance to the whole hospital structure of Canada;

THEREFORE BE IT RESOLVED,

(a) That all hospital associations and hospital workers be urged to make a careful and intimate study of the whole field of health insurance and the effect such system would have upon hospital development in Canada;

(b) That developments towards health insurance in the Dominion and Provincial fields be closely observed;

(c) That the best way to insure that any social

changes will be ultimately in the best interests of the people is to participate in the formation of any such policies in their early stages rather than to keep strictly aloof from these social movements;

(d) That the possibility of various forms of voluntary insurance meeting the needs of the people, without recourse to state control, should be fully studied;

(e) That any form of health insurance which would interfere with the autonomy of our voluntary institutions (except for necessary supervision of the expenditure of trust and public funds) or which would interfere with the future development or scientific objectives of such institutions, or which would destroy the spirit of freedom and charity or would place hospitals under political control, should be strongly opposed. (Carried).

The Canadian Hospital Council desires to thank the Royal Commission on Dominion-Provincial Relationships for its courtesy in permitting the Canadian Hospital Council to present this Brief on behalf of the hospitals of Canada. It is our earnest hope that out of these deliberations will arise a new Canada with an even greater future than that which has hitherto seemed possible.

Respectfully submitted,
HARVEY AGNEW,
Secretary, Canadian Hospital Council.

Lacombe Hospital Opened

A fine new hospital at Lacombe, Alberta, was opened by Doctor M. R. Bow, Deputy Minister of Health, in December. Miss Margaret Maloney will be retained as administrator.

Hull Sanatorium Opened

Doctor Arthur Powers has been named superintendent of the Hull Sanatorium, opened recently. It was constructed by the Quebec Government and the Grey Nuns of the Cross at approximately $400,000. Doctor Power was formerly with the Royal Ottawa Sanatorium and the Ontario Travelling Chest Clinic.

New Red Cross Hospital in British Columbia

A new 6-bed Red Cross Hospital has been opened at McBride, midway between Prince George and Jasper. Miss Grace Wright and Miss Innes Browne, both of Vancouver, will be matron and assistant, respectively. McBride has a population of 300, and is the centre of a huge ranching and farming area. A good house has been purchased, and will be converted for use as a hospital.

Ontario Hospital Association News

THE President of the Ontario Hospital Association presided at a meeting of representatives of Toronto Hospitals and the Provincial and Toronto Departments of Health, held a few days ago to form a local committee of arrangements to prepare for the combined convention of the American Hospital Association and International Hospital Association to be held in Toronto in September, 1939.

Dr. W. S. Caldwell, Assistant Director of the Ontario Division of the Red Cross, was appointed chairman and Mr. Carl Flath, Superintendent of the Wellesley Hospital, was appointed secretary.

These, together with Mr. A. J. Swanson, Dr. Harvey Agnew and Dr. Fred W. Routley were appointed to secure chairmen of a dozen sub-committees which are necessary to make this great convention a success.

It is to be hoped that all members of the Ontario Association will do everything in their power to assist the local committee, who undoubtedly have a very heavy task upon their hands in making all the necessary preparations for meetings lasting ten days and which are likely to be attended by six or seven thousand people.

* * *

A great many replies to Dr. Ferguson's questionnaire have come in and they are sure to prove useful in the preparation of a brief setting forth urgent needs of the hospitals of Ontario which will be presented to the Government of the Province.

* * *

The startling statement is made in the Quebec Chronicle-Telegraph that 91 of the 105 medical students in Laval University are residents of the United States. If these students pay their way in college, it will be a different condition than any we have ever heard about. Taking for granted then that similar financial conditions obtain as are found in other Medical Schools, our American friends must agree that Canada is doing its share to educate the rising generation of their citizens.

* * *

News from our clipping service shows that many Hospitals in Ontario have not sufficient beds to accommodate the sick of the community who are seeking hospital treatment. This condition exists notwithstanding the fact that patients are sent out at the very first moment they are fit to leave hospital.

There are two important deductions to be made from this condition; one is that undoubtedly hospitals are being considered increasingly more necessary in the treatment of disease; and the other is that more and more hospital beds must be supplied and this means the expenditure of large sums of money.

We understand that many hospitals in Canada are finding it difficult to secure a full complement in their nurse training classes. We believe this is a condition which is liable to give much concern in the near future.

Women's Hospital Aids Association
Province of Ontario, Canada

Association formed 1910
Individual Aid formed 1865

Don Quixote thought he could have made beautiful birdcages and toothpicks if his brain had not been so full of ideas of chivalry. Most people would succeed in small things, if they were not troubled with great ambitions

—Longfellow.

The greater number of hospital aid groups within the affiliation are already well advanced with plans for the years work. The achievements of last year are a creditable record and there is no reason for a lessening in any degree of ambition to reach a greater goal for this year.

Not striving for a place in the sun for either individual or group, but in doing the smallest services efficiently and understandingly, meeting the largest number of greater needs, whether it be in the gift of bootees for the indigent baby or providing the furnishings of a new wing; assistance given always in a whole-hearted and spontaneous response according to ability to meet the need; reaction to sound generosity and graciousness is perpetuated and reflects worthiness of purpose engendering a feeling of stability and enthusiasm for the cause of the hospital in the community. This in itself is an abuudant contribution to Public Relations and cements deep desire on the part of the citizen to assist when and wherever possible philanthrophy towards the institution.

Sometimes we are impelled by our own ideas rather than responding to the suggestions of those who are more conversant with hospital needs. True and efficient hospital aid members can only give of their best when close attention, sympathy and knowledge are exercised, understanding of requirements obtained from the superintendent and the board. The hospital superintendent and the board have a duty also in this regard, namely keeping the aid members fully acquainted with the best possible way of assisting the superintendent and the board in the quota desired of the aid.

Disputations carry away the mind from calm and sedate atmosphere lessening efficiency. Few disputes are managed without passion. Always remember "when you lose your temper you lose your argument." Suspense of judgments and exercise of charity are safer and seemlier for Christian workers. It is well to ponder all issues—think constructively, speak and act sincerely, work earnestly.

Margaret Rhynas.

New Hospital at Enderby, B.C.

A new wing, consisting of 8 rooms, a bath-room and a large basement, was officially opened recently at the Enderby General Hospital. A very interesting ceremony, attended by some 100 guests, marked the occasion.

Book Review

"MEDICAL RECORDS IN THE HOSPITAL", *by Malcolm T. MacEachern, M.D.*, Physicians' Record Company, Chicago, 373 pages.

The hospital field is again blessed with good fortune by the publication of Dr. MacEachern's most recent book, "Medical Records in the Hospital." All too long hospital administrators have suffered due to a dearth in authoritative literature on administrative problems but it would seem that recently our ill fortune has left us. Every administrator knows the value of good records and if he is sincere in his work he will leave no stone unturned in finding out the most efficient way to file and preserve such records in his hospital so that they may serve their utmost purpose. The author, who is without doubt our foremost authority on hospital administration in North America, has spared no effort in the preparation of his book to ensure that medical record work is completely covered. The ten chapters, beginning with the history of medical records, take the reader through the record library, into the record itself, show the relationship between departmental activities and the completed record, comprehensively deal with the modern filing of records and clearly define the value of the record to the patient, doctor, and institution. Of great interest to the reviewer is the chapter devoted to clinical photography. It has been a foregone conclusion for a number of years that photography would play a vital part in the compilation of a complete record but due to expense and trouble the method has not yet received popular acclaim, however, by the inclusion of this chapter in Dr. MacEachern's book he has officially given a status to such a procedure. To urge every hospital administrator and department head to get this book seems almost unnecessary for the reputation of the author is a guarantee of its value, particularly when it appears following the most discussed hospital textbook ever published, "Hospital Organization and Management."

Toronto General Appoints Successor to Doctor E. A. Gray

Doctor F. A. Logan of Lindsay, Ontario, has been named medical superintendent of the Toronto General Hospital, assistant to the general superintendent, Mr. C. J. Decker. He will succeed the late Doctor E. A. Gray.

New Manager at Metropolitan General Hospital, Windsor, Ontario

Mr. Thomas Gray, Secretary of the Windsor Utilities Commission, has been appointed Manager of the Metropolitan General Hospital by the hospital board of governers. He will succeed Mr. Ross Braid.

By-Laws to Effect Closer Link-up

The new By-laws of the American Hospital Association adopted in Atlantic City considerably change the type of organization, and a number of state associations are desirous of re-modelling their own set-up to conform with that of the continental organization. It would appear that closer co-operation could be effected, if there were this similarity in set-up.

Here and There in the Hospital Field

By HARVEY AGNEW, M.D.,
Secretary, Canadian Hospital Council

CALGARY, ALTA.—A most acceptable Christmas present was received by the Calgary Junior Red Cross Hospital for Crippled Children from the Right Honourable R. B. Bennett. Mr. Bennett paid off the mortgage on the hospital.

* * *

LONDON, CAN.—It is proposed that $250,000 of the money being left to the City of London by the Williams' Will should be set aside for an extension to Victoria Hospital, and a similar amount be set up as an endowment fund. The exact division of the estate will be determined by the provincial government. This illustrates again that the ownership of a hospital by a municipality does not necessarily close the doors to voluntary assistance. This same hospital profited greatly by the personal attention and financial assistance of the late Colonel Gartshore.

* * *

OTTAWA, CAN.—Hospital building committees will welcome the announcement that the National Research Council has approved the preparation of a model building code for Canada. This will be undertaken in collaboration with the Dominion Fire Commissioner and the Dominion Housing Administration. A strong committee of outstanding authorities has been named, and it is expected that they will be able to draw up a building code which will fully meet the necessary safety requirements and which will make full use of the newer principles of construction and the newer materials now available, the use of which has definitely altered the need for some of the restrictions and requirements specified in some of the municipal and other building codes. It is hoped that this report will serve as a model for municipalities wishing to enact or revise their building by-laws. At the present time a majority of the people of Canada live in communities without any municipal regulation governing construction.

* * *

PETROLIA, ONT.—Hospital workers in Ontario will regret to hear of the retirement of Miss Florence Ritchie from the superintendency of the Charlotte Eleanor Englehart Hospital at Petrolia. This little hospital has long been considered as a model small hospital. The chairman of its board, Major Moncrieff, took an active part in the organization of the Ontario Hospital Association becoming one of its early presidents. Since his untimely death, Miss Ritchie has maintained this interest in association activities, and has contributed extensively, both by personal contribution and by numerous hospital studies, to the advancement of hospital knowledge.

* * *

REGINA, SASK.—Speaking before the Rowell Commission, the Honourable Doctor J. M. Uhrich, Minister of Health for Saskatchewan, expressed the hope of the government that it would be possible to set up two small cancer hospitals for the diagnosis and treatment of cancer by a staff of specialists. In doing so, the Department would hope to repeat in the cancer field their successful efforts to combat tuberculosis.

* * *

ROCHESTER, N.Y.—Among the scores of interesting hospital cards received at Christmas was one from the Strong Memorial Hospital, outlining the Christmas programme in the hospital. There was a simple statement to the effect that each patient receives a small remembrance on Christmas Day, the packages being prepared for distribution by the wives of staff doctors. There is a description of the holiday decorations in the hosiptal, and then is given a calendar of the hospital activities including the formal dance of the nurses, the Christmas party for the nurses a week later, the delivery of Christmas baskets by the nurses to deserving families, the Christmas Day programme, starting at 5.30 a.m. with the candle-light procession of nurses and doctors and the singing of carols, and then following Christmas the tea in the Out-Patient Department for the doctors, nurses and aids. Doctor Basil C. MacLean, superintendent of this hospital, was formerly assistant at the Montreal General Hospital.

* * *

SAINT JOHN, N.B.—The Saint John General Hospital is greatly indebted to Doctor G. A. B. Addy, who for many years has been a leading member of the hospital staff and board, for his invitation to the superintendent to go into his library and select such volumes as would be desired for the shelves of the hospital medical library. For this action Doctor Addy received a hearty resolution of thanks from the hospital commissioners.

* * *

SASKATCHEWAN.—Saskatchewan now boasts the lowest tuberculosis death rate in the world. This rate would be still lower were it not for the still heavy death rate among Indians resident in that province. Speaking before the Rowell Commission, the Honourable J. M. Uhrich con-

trasted the low rate of 27.8 per 1000,000 population in 1935 and the figure of 29.9 for 1936 with the rate of 38 for whites in New Zealand, which had hitherto held the record. Ontario's rate of 36.8 in 1935 was also lower than that of New Zealand. The rate for all of Canada was 60.3. Much credit for this fine record of Saskatchewan is due to the excellent system of tuberculosis control developed in that province.

* * *

TORONTO, ONTARIO.—Not a single case of tuberculosis has developed in either the Toronto General Hospital or the Toronto Western Hospital during the past 4 or 5 years. In addition to the excellent provincial regulation requiring pupils to be given the Tuberculin Test, supplemented by X-ray examination, the hospitals have been using the Caulfield Inhibitive Test, which has been given extensive clinical application by Dr. W. E. Ogden and his associates at the tuberculosis clinic at the Toronto Western Hospital.

* * *

VICTORIA, B.C.—After twelve years, the Provincial Royal Jubilee Hospital has been rewarded for kindly service given to a public ward patient back in 1925. A prospector, then 70 years of age, was unable to pay but promised to repay the hospital if ever in a position to do so. He recently died at the age of 82, and left the sum of $400 to the hospital in his will.

* * *

Construction

The Sisters of St. John the Divine are considering the establishment of a hospital for epileptics. The location has

not been settled, but it is reported that the location will be somewhere in Western Ontario.

* * *

A $100,000 building programme in connection with the Public General Hospital at Chatham, Ontario, will be undertaken this year.

* * *

A $50,000 money by-law may permit, if passed, the construction of a $75,000 addition to the Chilliwack (B.C.) General Hospital. A two-storey brick building, providing for 40 beds is under consideration.

* * *

Work is to commence in the Spring on a $200,000 addition to the St. Joseph's Hospital at Glace Bay, N.S. A three-storey brick fire-proof building will be constructed to increase the capacity from 86 to 150 beds. Mr. B. Evan Parry of Toronto is the architect with Mr. Angus J. McCormick of Sydney as supervising architect.

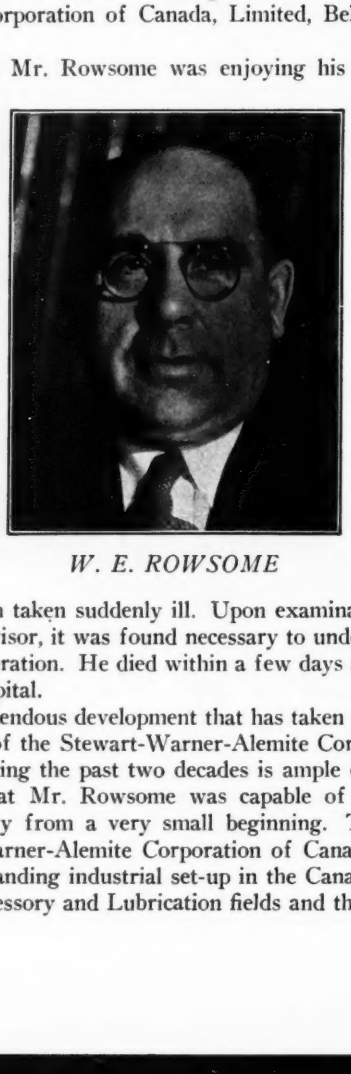
* * *

Construction of a $30,000 wing, which will accommodate an extra 27 patients, will be commenced in the early spring at the Great War Memorial Hospital at Perth, it is reported.

Mr. W. E. Rowsome Passes Away

Canadian industry lost one of its outstanding leaders in the untimely death recently of William Ernest Rowsome, President and General Manager of Stewart-Warner-Alemite Corporation of Canada, Limited, Belleville, Ontario.

The late Mr. Rowsome was enjoying his usual good



W. E. ROWSOME

health when taken suddenly ill. Upon examination by his medical advisor, it was found necessary to undergo an immediate operation. He died within a few days after entering the hospital.

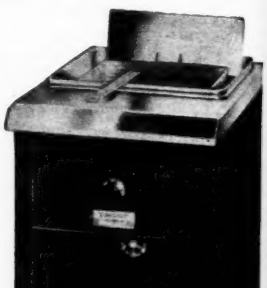
The tremendous development that has taken place in the expansion of the Stewart-Warner-Alemite Corporation in Canada during the past two decades is ample evidence of the fact that Mr. Rowsome was capable of developing this industry from a very small beginning. To-day, the Stewart-Warner-Alemite Corporation of Canada Limited is the outstanding industrial set-up in the Canadian Automotive Accessory and Lubrication fields and the Canadian Radio industry. Of particular interest in the hospital field is the extensive range of Bassick casters which this firm has marketed during the past few years.

In the last twenty years or more, there has never been one hint or suggestion that there might possibly be any difficulty in the plant for any reason whatever. In this respect the whole factory organization in Belleville is remarkable in its experience and record. The spirit and loyalty towards the man Rowsome was evidenced in the factory on the news of the sudden death of its President and General Manager. There was a feeling of tremendous loss and let-down. Every employee from floor sweeper through to the Department Managers felt that they had lost a friend, as well as an employer.

New Electric Fry Kettles

Two new automatic electric fry kettles, comprising a new larger-sized counter model and a new floor model, are announced by Canadian General Electric Company.

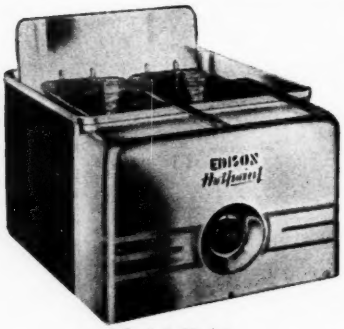
These kettles have been developed with an eye to greater economy, speedier frying, safety and simplicity of design, it is stated.



Model K-32.

The manufacturers claim further savings in fat with the use of either of these new models, due to the small fat capacity of 25 lbs. and the large frying area of 1¼ square feet. The accurate automatic temperature control proportions the amount of electric energy used to the number of orders fried, it is revealed, and it is as simple to set a temperature as it is to tune a radio. An electrical capacity of 7 kilowatts insures speed, frying capacity and quick recovery, it is claimed.

The K-31 model is provided with two baskets with dimensions of 6⅝ x 11⅝ x 5½ inches, while the K-32 model is provided with one large basket, 13⅞ x 11⅝ x 5½ inches. All baskets are interchangeable on either kettle, it is stated.



Model K-31.

The temperature control bulb is in direct metallic contact with the heating units and thus prevents overheating, it is revealed, and cleaning of the fat container, which is made of drawn steel, is facilitated because of the sloping bottom for drainage purposes.

It is further revealed that the new models have been constructed with a minimum number of parts and the kettles are sturdy and simply designed.